STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
5) 323-0503

September 30, 1985

CMSP LETTER 85-8

TO: All CMSP County Welfare Directors

REVISED FORM CMSP 239C (6/85)
CMSP NOTICE OF ACTION - INCREASE/DECREASE IN SHARE OF COST

This letter transmits a camera-ready copy of the revised form CMSP 239C. The Small County Advisory Committee approved the revision to include "decrease" in share of cost and, thereby, eliminating the need for another Notice of Action form.

The county is responsible for producing a supply of the forms for use. You may exhaust the current supply of the old form prior to using the revised form.

Please contact Linda McFarland at (916) 324-4203, if you have any questions concerning this revised form.

Sincerely,

Bacilio, Garcia, Chief
County Medical Services Program
County Health Services, Branch

cc: CMSP Contact Persons

LMF:lr

OCHB-3083
9/85

(County Stamp)

COUNTY MEDICAL SERVICES PROGRAM
NOTICE OF ACTION
INCREASE/DECREASE IN SHARE OF COST

Case No.: _____
District: _____
Increase/Decrease in Share of Cost for: _____
_____
(Names)

☐ Your share of cost has been increased/decreased to $ _____ per month beginning _____ because:

Enclosed is an additional RECORD OF HEALTH CARE COSTS for _____ (Month) . It shows your new share of cost for the month. Attach this form to the form you have already received for the month. Take both forms to any medical provider you see. If your medical expenses exceed this new amount, a CMSP card will be issued to you after the form has been completed and approved.

☐ ou have been assigned a supplemental share of cost of $ for the month _____ (Month) because:

Enclosed is a supplemental RECORD OF HEALTH CARE COSTS for _____ (Month) . It shows your supplemental share of cost for the month. If your medical expenses in the month exceed that share of cost, a CMSP card will be issued to you after the form has been completed and approved.

The regulations which require this action are California Administrative Code, Title 17, Section 1498, et seq.

Your new share of cost was determined as follows:

	Month
[Monthly gross income	$_____
Monthly net nonexempt income	$_____
Maintenance need	−$_____
Excess income	$_____
Share of cost	$_____

_____ (Eligibility Worker) _____ (Phone Number) _____ (Date)

CMSP 239C (6/85)

APPLICANT COPY
CASE COPY